3. *SOONERCARE* MCO AND PROVIDER PAYMENT MECHANISMS

Introduction

This section of the operational protocol describes the manner in which payments will be made to MCOs and PCCM physicians, as well as provider payment mechanisms for care furnished to individuals not yet enrolled in managed care. It also outlines the State's approach to reimbursing providers for services delivered to MCO or PCCM enrollees outside of the capitation, when the MCO/PCCM had already been capitated for those services. Finally, it includes a description of the State's supplemental primary care capitation payment for university physicians.

MCO/PCCM Payments

The State already has implemented a capitation payment system for MCOs, pursuant to start-up of its 1915(b) managed care program. The system includes eight capitation rate categories, each representing a different age/sex cohort within the AFDC population. The State does not publish rates within these categories, but instead has established confidential rate ranges, against which MCOs submit rate proposals. The specific steps followed in establishing the rate ranges were shared previously with HCFA, in a letter from the State's actuaries, dated April 3, 1995, and included here again as Attachment 7. The same process will be followed for the procurement to be conducted in the Spring of 1995, although the State and its actuaries will define new rate categories specific to the ABD population as part of this process.

In the case of PCCM providers, the State has defined a benefit package on a procedure code basis, which is outlined in Section 4 of the protocol. The historical dollar values of these services are currently being calculated by the actuarial firm of Coopers and Lybrand using information from the State's Medicaid claims database. Coopers and Lybrand will be responsible for estimating potential changes in utilization under managed care, and establishing actuarially sound capitation rates for rural areas based on sex and age categories.

The age and sex categories for PCCM providers will match those used in urban areas of the State. The rates themselves will be published and providers will be required to accept or decline them in total; there will be no rate bidding process akin to what occurs in the MCO service areas

Fee-for-Service Window

The State will reimburse providers for services delivered to individuals not yet enrolled in managed care using the existing Medicaid fee schedule. In setting capitation rate ranges or rates, the State's actuarial consultants first estimate the portion of total claims

associated with prior quarter coverage and the "fee-for-service" window period (the time after eligibility is determined but before managed care enrollment takes effect) and remove these dollars from the capitation pool. By doing so, the State is able to assure that it remains below the upper payment limit for enrolled populations and does not capitate MCOs or PCCM physicians for services they will not be providing.

Services Delivered Outside of Capitation

There are four services in the *SoonerCare* program for which MCOs and PCCM providers will be capitated, but which still can be obtained on a fee-for-service basis under certain conditions. These are: EPSDT screens, family planning services (for adolescents), child abuse examinations, and IHS services delivered to IHS beneficiaries[2]. In the first two cases, if an outside provider meets the conditions for furnishing the service (conditions are described in the State's MCO RFP previously given to HCFA), he or she will submit a claim to the State and will be reimbursed under the existing fee schedule. The State then will deduct the value of this payment from the MCO or PCCM provider's next capitation check. The same methodology also will be followed in the third case (child abuse exams) for MCOs, but not for PCCM providers, as this service is not part of the PCCM benefit package.

Universities Primary Care Supplemental Payment

The 1115(a) waiver acknowledges the special mission of Oklahoma's two medical schools, which are located in Oklahoma City and Tulsa, to undertake teaching and research to benefit all residents of the State. The 1115(a) waiver also recognizes the importance and unique role those institutions play in the delivery of health care to indigent and Medicaid recipients. Accordingly, the State has established a procedure that will partially compensate the medical schools for the teaching component of their mission.

Specifically, each of the universities will be permitted to submit a list to the State on a quarterly basis, documenting the *SoonerCare* beneficiaries, by rate category, who are using one of its physicians as a primary care provider. The State then will verify the accuracy of the list against its own enrollment records and will make a PMPM payment to each university for these persons. The size of this PMPM for Tulsa clients will be equal to four percent of the Statewide blended capitation rate (separate for each rate category) and for Oklahoma City clients five percent of the Statewide blended capitation rate (separate for each rate category). The Oklahoma City supplemental payment has been set slightly higher in acknowledgement that the University of Oklahoma Health Sciences Center, in Oklahoma City, is a comprehensive tertiary teaching center, while the university provider sites in Tulsa are not.

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[2]This last service will be addressed in Oklahoma's supplemental protocol submission concerning IHS beneficiaries.

As with monies required for prior quarter coverage and fee-for-service window payments, Oklahoma's actuarial consultants estimated the likely value of this supplemental payment to the universities and removed these dollars prior to setting MCO capitation rate ranges. ***An*** identical process will be followed for the SFY 1997 MCO procurement, thereby assuring that the State will be able to remain below the program's upper payment limits.

4. *SOONERCARE* BENEFIT PACKAGE AND EPSDT INITIATIVES

Introduction

This section of the operational protocol outlines the benefit package for managed care enrollees in MCO and partial capitation regions of the State. It begins with a general overview of benefits in both areas and then discusses various components of the benefit package in greater detail. It also compares existing benefits under the fee-for-service program to what will be offered through managed care. It concludes with a discussion of the State's approach to raising compliance with EPSDT periodicity schedule targets.

General Benefit Package (MCOs and Partial Capitation)

MCOs will be required to furnish a comprehensive benefit package which includes most services currently covered under Medicaid. They also will be required to offer certain enhanced services, such as wellness programs, that the State believes could have a positive effect on overall member health status.

A copy of the current 1915(b) program benefit package for the MCOs is included as Attachment 8 to this document. This benefit package will also be used for contracting with MCOs under the 1115(a) program.

A copy of the State'srural capitated benefit package for PCCMs is included as Attachment 9. The services indicated in this package will be reimbursed at a single capitated rate. Services outside this package will be paid on a fee-for-service basis.

Depending on the model(s) operating in different areas of the State, there will be differences in the scope of benefits available to MCO and PCCM enrollees, primarily due to the manner in which existing program service limits are being treated under managed care. In the current program, adults services are subject to the following limits:

- Twelve hospital days per year
- Two physician office visits per month
- Three prescriptions per month

Under the MCO model, all these service limits have been eliminated and MCOs will be required to furnish any care that is deemed to be "medically necessary". Under the PCCM model, primary care visits will be capitated and will no longer be subject to limitations on the number of office visits. However, the following limitations on services still will apply:

- Twelve hospital days per year
- Two specialist (referral) physicians visits per month
- Three prescriptions per month

Also, enrollees under the PCCM model will not be eligible for the schedule of "enhanced" services that MCOs are being contracted to deliver. These include: smoking cessation classes, childbirth education classes, parenting classes, and nutrition counseling.

While adult participants in the PCCM program will receive fewer benefits than their MCO counterparts, it is important to note that their benefits will not be diminished as compared to the current system. In fact, because the physician visit limit under the PCCM model will only be in place for visits to specialists, these clients will be receiving a modest increase in benefits as compared to the existing program.

Behavioral Health Services

In the MCO model, comprehensive mental health services are part of the benefit package and are provided by the MCOs. At their option, MCOs may provide an additional array of non-mandated alternative services approved by the State. MCOs must have their own mental health case managers to facilitate direct access to mental health and substance abuse services. PCPs may not serve as mental health case managers. However, the PCP is responsible for coordination of mental health services with medical services.

MCOs must provide medically-necessary inpatient psychiatric care and restrictive residential treatment for all eligible members. MCOs are fully liable for mental health services up to a dollar limit of $10,000 per member. Beyond that amount, the State will pay 70 percent of any additional claims based on the Medicaid fee-for-service payment rates. At their option, plans may provide non-mandated services approved by the State, with the Medicaid value of such services counting toward the above threshold. There are no limitations on dollars, days or visits within this threshold. Determinations of whether individuals have reached the threshold will be made using reports of encounters submitted by all health plans. The State is mandating 100 percent encounter reporting for all services, including behavioral health services.

Behavioral health case managers are responsible for making referrals for mental health services and monitoring utilization. MCO members can self-refer to a mental health provider for an initial visit, but authorization from the case manager is required for subsequent treatment. MCO mental health case managers must be mental health professionals who meet, at least, the qualifications of mental health service providers as defined under the program and could include:

- Psychiatrists
- Psychologists
- Licensed Marital and Family Therapists (LMFTs)
- Licensed Professional Counselors (LPCs)
- Licensed Clinical Social Workers (LCSWs)
- Psychiatric Nurse Specialists

In addition, Certified Drug and Alcohol Counselors (CADCs) may act as case managers for substance abuse services, if they are supervised by one of the licensed professionals listed above.

In recognition of the special needs and considerations necessary to provide appropriate case management, outreach and medical and behavioral health treatment for persons with serious mental illness, this population will not be included in the program during at least the first three years. This includes both adults with serious mental illness and children who are severely emotionally disturbed. In areas of the State using the PCCM model, all behavioral health services will continue to be reimbursed on a fee-for-service basis.

Obstetrical Services and Prenatal Care

Under the MCO model, prenatal and obstetrical services are part of the benefit package and OB/GYNs may serve as PCPs at the discretion of the plan. If the plan does not elect this option, pregnant members must be allowed to select a network obstetrical provider for pre-natal care, delivery and follow up care until 60 days postpartum.

MCOs are also required to conduct outreach with pregnant members, to ensure they begin receiving prenatal services-at the earliest possible opportunity. At member orientation, members are encouraged to notify their MCOs that they are pregnant so that a risk assessment survey can be conducted by telephone. If the member is found to be at risk, she is targeted for mandatory maternity case management which may include health and nutrition counseling, substance abuse counseling, smoking cessation, as well as making the member aware of other community resources.

In rural areas, the State obstetrical and prenatal services are outside of the capitated PCCM benefits package. The State will continue reimbursement in the current manner for these services. Women who are enrolled with a primary care provider and become pregnant will have the choice of remaining with that provider (if he or she offers obstetrical services) or changing to another provider. In either case, the State will cease making capitation payments and will compensate the OB provider using its existing global payment methodology.

This decision was based on the State's belief that the global payment methodology approximates a capitation rate and because the State has historically been successful in finding rural providers willing to serve Medicaid patients under this arrangement. There will be no reduction in the amount, duration, or scope of OB services for individuals under this model. While, the PCCM model does not include a specific component for maternity case management, a streamlined procedure has been implemented which will greatly reduce the time it takes for completion of presumptive eligibility determinations. Thus, pregnant women will be able to link with their obstetrical provider much sooner.

Dental and Vision Services

In the MCO/Outpatient Network models, dental and vision services for children will be included in the pre-paid benefit package. However, dental and vision services for adults are not currently covered by Medicaid, and therefore, will not be covered under the demonstration.

MCO members will be permitted to self refer to any optometrist or ophthalmologist in their network for covered vision services and to any network dentist covered dental services. Once a member accesses a provider for dental or vision services, including refraction services, the practitioner will be authorized to provide any medically necessary eye or dental services within their scope of practice, as defined by Oklahoma law, for which they have received appropriate training and certification.

Pharmacy Services

MCOs are required to cover all FDA-approved medications subject to the restrictions outlined in Section 1927(d)(2) of Federal regulations (OBRA '90 rules). **If** they wish, MCOs may develop a preferred-drug list based upon the application of clinical guidelines. Under the clinical guidelines, there must be inclusion of drugs in each of the therapeutic classifications identified by the State (See Attachment 10). All clinical guidelines must be submitted and approved by the State prior to implementation by the MCO. The Oklahoma Drug Utilization Review Board will review the guidelines for clinical deficiencies prior to implementation.

When new members are enrolled into an MCO, they will not be immediately subject to the formulary limitation of that plan. Instead, they must be allowed to obtain their covered prescribed medication unless and until new medications are prescribed by the PCP. However, the MCO pharmacy provider is free to make a generic substitution whenever such a substitution is considered both bioequivalent and clinically efficacious. MCOs must also administer a brand name exception process whereby a member, in consultation with the PCP, may seek coverage for brand name medication when there are indications that it is medically necessary.

Under the PCCM model, prescriptions will remain a fee-for-service benefit. Accordingly, the current limits on prescription benefits will still apply.

Emergency Services/Urgent Care Services

Emergency room services are included in the prepaid benefit package for MCOs. Services for conditions which are true medical emergencies are covered through the plan without prior authorization, regardless whether the member presents at an in-network or out-of-network facility. However, the MCO may require the member to contact the plan within **48** hours for authorization to obtain follow-up or continued treatment. MCOs

must advise clients in their member handbook that they: 1) have a right to obtain emergency services immediately; 2) at the nearest facility available; and, 3) are not restricted to MCO network facilities.

MCOs must provide care for urgent medical problems within twenty-four hours. Urgent care is defined as services which are unexpected but do not constitute an immediate threat to life or limb. Health plans are also required to provide members access to a 24-hour, toll free nurseline to assist members in determining the appropriate way in which to access the health care delivery system.

MCOs are allowed to set their own internal guidelines with regard to payment for urgent care in the Emergency Room. They may elect to pay a triage fee for assessment, or they may reimburse only for emergency services. Through the encounter data, the State is monitoring Emergency Room utilization to insure that members are being allowed appropriate access.

Under the PCCM model, emergency services for true emergencies are outside of the capitated benefit package and will be reimbursed fee-for-service. Members can access any facility for medical or mental health emergency care. Authorization from the PCCM is not required. However, authorization from the PCCM would be necessary for any follow-up treatment. **As** part of their case management functions, physicians are expected to be actively involved in the education of patients on the appropriate use the Emergency Room.

PCCMs are required to provide urgent care services to their members within 24-hours. If a member presents at the emergency room with a non-emergency condition, the emergency room must contact the PCCM for authorization to provide services. If services are provided without authorization, the claim will be denied and no reimbursement will be made by the State.

Family Planning Benefits

Family planning services include contraceptive medical visits, family planning education and counseling, birth control methods ordered at a comprehensive family planning exam, tubal ligations and vasectomies. Adults enrolled in health plans must obtain family planning services through their MCO. However, adolescents who choose to do so may obtain services outside the network.

A comprehensive family planning exam is defined by the State as a complete exam including evaluation of weight, blood pressure, extremities, breasts, abdomen, and pelvis which is conducted in such a manner that the provider is able to extract the information necessary to rule out contra-indications to any contraceptive method the member might choose. Appropriate laboratory tests which may be **part** of this exam include: pap smear and hematocrit, culture for N. Gonorrhea from endocervix and rectum, culture for chlamydia, serologic test for syphilis, pregnancy test and rubella screen (or

immunization), if indicated. Optional laboratory services or procedures to be complete on an as needed basis include: urethral smears and cultures for gonococcus in asympotomatic males, skin test for tuberculosis, dextrostix followed by modified glucose tolerance test, other immunizations including oral polio vaccine, and sickle cell screening.

Additionally, as part of the exam, MCOs or other Family Planning provider is expected to include the following services, all of which are included in the plan's capitation:

- Risk assessment of unintended pregnancy, poor pregnancy outcome or need for family support services

- Pregnancy Diagnosis and Counseling-Diagnosis of pregnancy--members who are diagnosed as pregnant will be provided information on all legal options available for unintended pregnancies and if they desire will be referred for appropriate obstetrical and gynecological services. Other members will be given information about the availability of contraceptive methods.

- Education-including the reasons family planning is important for the maintenance of individual and family health, basic information regarding reproductive anatomy, and risk factors and complications of various contraceptive methods, information on methods of transmission, diagnosis and treatment of STDs, AIDS/HIV education, and the procedures of self breast examination.

In the PCCM model only an office visit, pelvic exam and pap smear are part of the capitation, therefore, any other component will be billed fee-for-service. Adults must either obtain medically-necessary family planning services from the PCCM or obtain a referral from the PCCM to an appropriate family planning provider. If referrals are made by a PCCM to a family planning provider for services that were included in the capitation rate, the PCCM will be responsible for reimbursing the family planning provider.

Services outside the capitated package will be reimbursed by the State at the fee-for-service rate. Adolescents may receive family planning services from any authorized provider. In the event an adolescent member chooses to access services outside the network the State will reimburse the family planning provider and may deduct the established fee-for-service rate for an office visit, pelvic exam and pap smear from the PCCM's capitation.

In order to ensure coordination of care, if a member is referred to a family planning provider by the PCP or PCCM, it is expected that the referring physician will receive information from the family planning provider for the member's record regarding the care given. However, when a member self-refers for family planning services, information will not be provided to the PCP or PCCM unless it is discussed with the member and the member understands and gives written consent. In addition, the State will provide financial infomation to the PCP or PCCM indicating that a deduction was made from the

capitation rate. However, this information will not indicate which member received the service.

"Enhanced Services"

In addition to delivering medical and behavioral health services, MCOs are required to furnish a package of "enhanced services" as part of their commitment to illness prevention. The enhanced service package includes:

- Smoking cessation classes-with targeted outreach for adolescents and pregnant women
- Childbirth education classes
- Nutrition counseling-with targeted outreach for pregnant women
- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, signs of illness and discipline.

Though the contractor is free to provide these classes through a variety of means, the State encourages the use "traditional providers" for this purpose since they have a better understanding of the specials needs and risk factors associated with the Title XIX population. These traditional providers include Planned Parenthood, Health Departments, Community clinics, and FQHCs. To further encourage their use, enhanced services must be offered in a setting which is easily accessible to the members and must be available both during the day and in the evening.

MCOs must also provide enhanced case management services for pregnant women who fall into a high-risk category. These services include early identification of the at **risk** member, assistance in scheduling appointments, follow-up on missed appointments, providing or facilitating transportation to medial visits or educational classes, making the member aware of other community services available. At such time **as** the ABD population is brought in, MCOs will also be required to include enhanced case management services for that population.

Services Excluded from the Pre-Paid Benefit Package

A limited number of Title XIX services are not included **in** either the **MCO** or **PCCM** capitated benefit package and will continue to be reimbursed by the State on a fee-for-service basis. This limited set of services includes non-emergency transportation, services ordered through an IEP or IFSP, court-ordered treatments, and non-State plan services ordered as the result of **an** EPSDT screen.

With respect to non-emergency transportation, the State intends to implement new benefit guidelines for rural beneficiaries which will be tested during the tri-county **PCCM** pilot project. Currently transportation requests are handled by the member's case worker in the

county Department of Human Services office. Other than the case worker's signature, no authorization is necessary. However, when the PCCM model is implemented in the rural areas of the State, transportation for primary care and specialty services will require the PCCM's authorization to be reimbursed. Since members must select a PCCM within their county or contiguous counties and in most cases within 30 miles of their residence, reimbursement for transportation to a primary care visit will be limited to payment for no more than 30 miles.

Transportation reimbursement for authorized specialty care services will be made for actual map miles as indicated by mapping the addresses on the *GEO **Access*** mapping program. If a specialty visit is obtained without the authorization of the PCCM, the State will not reimburse for travel unless the specialist provided one of the self-referral services such as family planning, dental services, vision services, or mental health services. Authorization for out-of-state transportation will not be made by the case worker or an out-of-state PCCM, but instead by the Authority's Medical Director based on medial necessity and the availability and accessibility of in-state providers.

During the DHS enrollment training in rural counties, the new guidelines regarding transportation will be issued and all county workers will be trained in the changes in procedure and the need for authorization. The Medical Director's office will review claims for transportation with regard to utilization patterns to determine which county offices, providers or members are over-utilizers. When over-utilization patterns are identified, the State will develop a corrective action plan which could include retraining of county office workers, retraining of providers, and member education or assistance in selection of a provider within the specified geographic range. The State is also looking at restructuring the claims payment process to reduce administrative cost.

EPSDT Compliance

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, except non-State Plan services, are included in the pre-paid benefit package for children and adolescents under both the MCO and PCCM models (limited to primary care services for PCCMs). MCO and PCCMs are required to commit to achieving at least an eighty percent (80%) compliance rate for EPSDT screening schedules among all of the children and adolescents they serve.

In order to achieve the targeted compliance rate, MCOs and PCCMs will be required to make the EPSDT program one of their highest priorities. **As** part of their contracts, MCOs will be mandated to do the following:

- Educate families with children about the EPSDT program and its importance to overall health

- Educate providers about the EPSDT program and their duties and responsibilities under it

- Conduct outreach including mail-outs, telephone calls, home visits, health fairs or regularly scheduled meetings

- Schedule appointments for children and adolescents pursuant to the EPSDT periodicity schedule and conduct follow-up with children and adolescents who miss or cancel appointments

- Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are made pursuant to findings from an EPSDT screen

Prior to contract award, MCOs also will be required to demonstrate that they have an adequate number of providers who are geographically distributed in proximity to members, and who understand and are willing to participate in the program. Plans must further document whatever access points have been made available for members for EPSDT services, such as contracts with health departments or school-based clinics.

In areas targeted for inclusion in the partial capitation system, the State will take contracts with providers, such as health departments and school-based clinics, into consideration when considering whether a region has sufficient resources to support a managed care model.

Following contract award, the Medical Director's office will review encounter data, as well as documentation for reimbursement submissions, to determine any patterns which would indicate that a particular MCO or an individual PCP or PCCM is negligent in providing EPSDT services. If an under-utilization pattern is identified, the Business and Contract Manager will take corrective measures.

Specifically, the MCO or PCCM will be notified in writing within thirty days of the State's discovery of the under-utilization pattern that there are indications that access to and utilization of EPSDT services is below the compliance rate. The MCO or PCCM will be given a specific deadline of not less than ten days in which to acknowledge the deficiency and develop and implement a corrective action plan.

If a corrective action plan is not initiated and if under-utilization patterns continue, the State will consider the imposition of financial sanctions until the non-compliance is corrected. Under the PCCM model, the State will follow the same procedures except that for those providers who are not in compliance with EPSDT standards, the State also reserves the right to:

- Restrict members from being auto-assigned to the provider who is out of compliance

- Impose a limit on the number of members who can choose the provider, and/or
- Revoke the provider contract and/or refuse to contract with the provider in the nest contract year

As described briefly in section 2, the State is further encouraging PCP/PCCMs to furnish EPSDT services by including a contract provision which allows school and health department clinics to conduct screening examinations on children who have not been kept current by their PCP/PCCM. In this setting, if it is ascertained that a child is not current, the school or health department clinic must first contact the PCPPCCM and attempt to set up an appointment for the child within ten business days. If the PCPPCCM cannot meet this condition, the clinic will be permitted to conduct the screen and bill the State fee-for-service. The State in turn will deduct the cost of the screen from the plan/provider's capitation payment.

In order to be reimbursed, the school or health department clinic must submit a claim for reimbursement to the State, as well as documentation that 1) the PCPPCCM was initially contacted and an appointment could not be obtained within the specified guidelines and 2) a guarantee that the PCP/PCCM will receive information for the patient file regarding the diagnosis, services rendered and need for follow-up. This documentation is submitted to the Medical Director who will use it verity that PCP/PCCMs have first been contacted and school and health department clinics are providing PCP/PCCMs with the information necessary to ensure continuity of care.

In the event that documentation is not submitted the request for reimbursement will be pended and a letter will be sent to the school or health department clinic requesting information. If the service has been provided without notification of the PCPPCCM, then the State will not pay the claim. This reimbursement mechanism is outlined in the provider contract between the State and school and health department clinics as well as in MCO and PCCM contracts.

5. MARKETING AND OUTREACH

Introduction

This section describes ***Soonercare*** marketing and outreach policies. It contains two parts. The first half describes the State's policies regarding preparation, approval and distribution of enrollment materials and for education of providers and of State personnel responsible for client outreach and enrollment. The second half contains the marketing guidelines that have been established for MCOs.

Marketing Policies

Overview

The State will use a variety of mediums to develop awareness and educate urban and rural clients about the ***SoonerCure*** program. If available, groups and individuals who have an interest and concern for the Medicaid population, such as advocacy groups for children, the disabled and the elderly and State agencies involved in targeted programs for these populations, will be utilized to increase awareness and educate the targeted population on the changes resulting from the movement to managed care. The challenge is to reach the targeted Medicaid population, capture their attention, and then present the information in a manner and at an academic level that is appropriate and effective.

Distributing written material related to the ***SoonerCure*** program to the urban and rural areas will be a priority for the State. Each DHS county office will be provided with the appropriate enrollment packets and informational brochures that detail the ***Soonercare*** program in each catchment area. In addition, the State intends to mail enrollment and educational materials to those who do not visit a county office. In cases where clients do not enroll through county offices, the State will conduct intensive outreach to ensure clients understand their enrollment options, requirements of the program and their rights under the program.

At the present time, two separate enrollment packets and educational brochures will be utilized - one designed for the urban health plan/Rural Partner catchment areas and the other tailored for the rural PCCM model. When Outpatient Networks are implemented, customized enrollment packets will be developed for them as well.

Urban Enrollment Packet

The urban enrollment packet will consist of five parts (a sample packet has been enclosed along with this protocol):

1. Pocket Folder - This is designed to transport the three inserts that describe specific elements of the ***Soonercare*** program as well as the enrollment card. Further, it will

provide the recipients with directions on how to proceed with the enrollment process and display the toll-free number should they have questions. The pocket folder will utilize a two colors of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of **8** 1/2" X 5 1/2".

2. Insert #1 - This insert carefully describes the ***SoonerCare*** program in the urban catchment areas and provides the recipient with fundamental concepts related to managed care. The ***Soonercare*** toll-free number is prevalent throughout the insert. The insert will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2".

3. Insert #2 - This insert is the Health Plan comparisons. Each MCO is given two (2) 8 1/2" X 5 1/2" panels to market themselves. The information that the Health Plans provide the OHCA to include in this insert must be at, or below the sixth grade reading and comprehension level. The insert will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of **8** 1/2" X 5 1/2".

4. Insert #3 - Important facts about ***Soonercare*** are included in this brochure. It is designed to inform recipients about their rights as well as their responsibilities as a *SoonerCare* member. The insert will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2".

5. Insert #4 - This insert is the enrollment card for the ***SooizerCare*** program. Recipients can fill it out at the time of their application, mail it in at a later date or call the toll-free number listed to enroll by phone. It provides them with step-by-step directions on how to complete the form and reiterates the time they have to choose a Health Plan and doctor. This card also is designed as a self-mailer that requires no postage on the part of the recipient. The card will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of ***8*** 1/2" X 5 1/2". **A** self-adhesive strip will be incorporated to seal the card for transport.

Provider directories will be placed in the DHS county offices by the individual MCOs to assist the recipients in their selection of a Primary Care Physician. For those who may not come into the county offices, provider directories will be mailed along with the enrollment packet and educational information. In addition, clients who receive enrollment materials in the mail will receive a cover letter explaining the program, detailed instructions (at a sixth-grade level) about how to fill out the enrollment materials and a schedule of orientation meetings conducted by the State (for detailed information regarding the enrollment process, see section ***6.)***

Rural PCCM Enrollment Packet

Rural enrollment will be initiated through mailing of an enrollment packet to all eligible recipients. The rural enrollment packet will consist of four parts:

1. Pocket Folder - This is designed to transport the two inserts that describe specific elements of the *SoonerCare* program as well as the enrollment card. Further, it will provide the recipients with directions on how to proceed with the enrollment process and display the toll-free number should they have questions. The pocket folder will utilize a two colors of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2".

2. Insert #1 - This insert carefully describes the ***SoonerCare*** program in the rural catchment areas and provides the recipient with fundamental concepts related to managed care. The ***SooizerCare*** toll-free number is prevalent throughout the insert. The insert will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2".

3. Insert #2 - Important facts about ***SoonerCare*** are included in this brochure. It is designed to inform recipients about their rights as well as their responsibilities as a ***SoonerCare*** member. The insert will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2".

4. Insert #3 - This insert is the enrollment card for the ***SoonerCare*** program. Recipients can fill it out at the time of their application, mail it in at a later time or call the toll-free number listed to enroll by phone. It provides them with step-by-step directions on how to complete the form and reiterates the time they have to choose a MCO and priomary care provider. This card also is designed as a self-mailer that requires no postage on the part of the recipient. The card will utilize a single color of ink printed on Gypsum Passport Cover by Cross Pointe with a total folded size of 8 1/2" X 5 1/2". A self-adhesive strip will be incorporated to seal the card for transport.

The obvious difference in the rural and urban enrollment packets is the elimination of the MCO comparison insert in the rural catchment areas. Under the PCCM model, clients will not choose an MCO, only a Primary Care Case Manager. In the catchment areas where the State develops "Rural Partners", the MCO comparison insert will be restored in the enrollment materials. Further, provider directories will be mailed to clients in the rural areas along with the rural enrollment packets to enable them to select a family doctor. In addition, packets will contain a cover letter summarizing the program and a handbook, written at a sixth-grade level, describing the program in detail. Information will include instructions on how to access providers other than PCCMs (for additional details regarding the enrollment process, see section ***6.)***

SoonerCare Educational Information for Urban and Rural Delivery Models

The State will develop educational brochures that distill further the information contained in the enrollment packets. These materials will describe the fundamentals of the ***SoonerCure*** program and detail how a beneficiary can obtain additional information and learn if they are eligible to participate. By limiting this information to a single sheet, the

State hopes to provide beneficiaries with a baseline understanding of the ***SoonerCare*** program without overwhelming them.

The brochures will be distributed with enrollment packets and also placed in the DHS county offices. Advocacy groups that interact with the Medicaid population will be provided with the materials to facilitate the educational process related to the ***SoonerCare*** program. MCO outreach representatives will also be given the brochure for use in their marketing efforts. The brochures will utilize a single color of ink and be printed on 8 1/2" X 11" tri-folded Futura text weight paper stock.

The State will also develop a culturally-sensitive brochure tailored specifically for the Native American population affected by the ***SoonerCare*** program. This brochure will detail the rights that IHS beneficiaries have in regard to their ability to utilize **IHS** providers as well as providers contracted under the ***SoonerCare*** program. Further, the State will investigate the prospect of including various tribal dialects in a specific section of the brochure that directs the individuals to get the information translated. This brochure will accompany all enrollment and educational materials. The brochures will utilize a single color of ink and be printed on 8 1/2" X 11" tri-folded Futura text weight paper stock.

All enrollment and educational materials will be written at, or below, a sixth grade level and will provide recipients with a basic understanding of managed care and how to properly utilize their health care services under a new delivery system. Further, all enrollment and educational materials will be translated into Spanish. This is the only non-English speaking group that comprises a significant percentage of the ***SoonerCare*** population.

Videotapes detailing the ***SoonerCare*** program and its enrollment process will be distributed to each DHS county office. This videotape will feature an Oklahoma celebrity who has State-wide name recognition and will incorporate bright colors, music and graphics to capture the attention of the viewers. The videotape is designed to augment the enrollment process by serving as a major information source for those individuals who have minimal reading and comprehension skills or those who are averse to reading. It will take the viewer through each element of the enrollment packet and address commonly asked questions about the ***SoonerCare*** program.

Due to the differences in the urban and rural health care delivery models, initially **two** videotapes will be produced. One will address the urban, fully-capitated style delivery while the other will address the PCCM partially-capitated moael. The rural videotape will address health care delivery mechanisms to keep costs down and quality of service high. It will familiarize the population with the **varying** types of health care delivery they can expect to encounter in the rural areas of the State.

In addition to providing videotapes to county offices, the State will make them available to advocacy groups and individuals who represent the interests of the Medicaid

population. Ideally, the video will be shown regularly to potential, as well as current beneficiaries, to develop awareness and educate them about the changes in their health care delivery. If asked, the State will make efforts to send representatives to the viewings to answer any questions that might arise.

The State will provide each DHS social worker with a script that outlines the ***SoonerCare*** program and enrollment process. Usage of this script will ensure that each health care offer is uniform and addresses all relevant information. Appropriate language will be used in the script that corresponds to the sixth-grade level attained in the enrollment packet and informational brochure. Further, references to the ***SoonerCare*** toll-free number will be made regularly to familiarize the potential recipient with the means of getting their questions answered.

For those individuals who do not come into contact with a social worker, the State will mail an enrollment packet as well as the informational brochure and provider directories. The enrollment packet and informational brochure will have the toll-free number clearly indicated for the client to call should they have any further questions. In addition, the State will investigate the possibility of using its phone agent as a means to do follow-up with the recipients after the enrollment packets have been sent.

The State is exploring the development of Public Service Announcements (PSAs) as a method of generating awareness of the ***SoonerCare*** program state-wide. If the State determines that this concept is viable, the PSAs will be produced at an appropriate academic level so the information can be fully comprehended by the targeted Medicaid population. Further, the Authority will then negotiate with various television and radio stations throughout the state to broadcast the PSAs. Gaining access to broadcast facilities that produce optimal geographic coverage will be a priority.

In addition to the development and distribution of Public Service Announcements, the State will examine the feasibility of utilizing the Oklahoma Educational Television Authority (Oklahoma's Public Broadcasting Service) as a State-wide broadcast mechanism for the enrollment video. This would be an efficient method of reaching the targeted Medicaid population. In order to inform the population of the upcoming broadcast, postcards could be sent a week in advance to notify the individuals of the date and air-time.

Education, Marketing and Outreach Strategy for Providers

The State will utilize the Satellite Training Network (SATTRN) through the Department of Human Service's Center for Professional Development to educate participating providers throughout both urban and rural regions. The Center for Professional Development will coordinate sufficient downlink sites to accommodate all of the providers. Vocational/technical schools and facilities that have operational satellite downlink capabilities will be targeted for the education and outreach session.

The design of the satellite program will allow for two-way interaction with the State and the rural providers. **A** toll-free phone bank will be available along with a fax machine to take written questions. In addition, working through various local professional organizations, individual meetings will be held with providers throughout the State to discuss the *SoonerCare* program and the various policies and methods of health care delivery.

Education, Marketing and Outreach Strategyfor Social Workers

The State will also use SATTRN to educate DHS social workers in the urban and rural regions on their role in the *SoorzerCare* program. Each county office should have the capacity to receive the broadcast. If not, vocational/technical facilities will be used to accommodate those who do not have downlink capabilities. Two-way communication will be available through a toll-free phone line as well as a fax machine that will receive written questions. In addition, individual meetings will be held with the social workers and their supervisors throughout the State to discuss the *Soonercare* program.

Education Of Urban Beneficiaries about "RuralPartner" Characteristics

The State will develop a printed educational brochure to be distributed to all urban beneficiaries affected by an MCO's change in status to a "Rural Partner." The brochure will accompany the enrollment materials to be sent during the open enrollment period. The information contained in the brochure will cover issues directly affecting the recipients such as the six month guaranteed eligibility, health plan lock-ins as well as lock-ins to provider networks for adults receiving family planning services. Further, the State will examine the possibility of using the phone agent as a means of follow-up after the mailing to assure the recipients understand the changes that will affect them. The brochure will utilize a single color of ink and be printed on 8 1/2" X 11" tri-folded Futura text weight paper stock.

Prior to release of the brochure, the State will educate DHS personnel on the changes resulting from the movement to the 1115(a) waiver from the 1915(b). Training will be conducted through group meetings as well as through distribution of written materials describing the characteristics of the new program.

The State will also encourage MCOs to contact their members via their member services departments or hold meetings with their Medicaid clients on the changes that will affect them under the 1115(a) waiver. State representatives will attend these meetings if requested.

Methodologyfor Reviewing Health Plan Marketing Materials

The State will require that all marketing information be submitted for approval prior to release by MCOs. Marketing materials consist of, but are not limited to: Flyers, ads, letters, brochures, sponsored events, etc. The marketing information can be mailed,

delivered by hand or faxed to the State's marketing liaison. It is imperative that each MCO allow for the review process in the development of their communications time line.

The State will appoint one individual to serve as the MCO marketing liaison. The MCOs participating in the *SoonerCare* program will submit all of their marketing materials to the liaison to begin the approval process.

Once materials have been received, the liaision will share them with a marketing review team consisting of representatives from the Divisions of Managed Care, Health Policy, Legal and Public Information. This team will be responsible for carefblly examining the materials to assure that they are accurate in their depiction of the ***SoonerCure*** program and are not misleading or coercive in any way.

All marketing materials submitted to the State will be reviewed within 10 working days. If corrections or changes are recommended by the review team, the changes must be made and the materials re-submitted to the State for final approval.

The providers who have contracted with the MCOs are also mandated to submit their marketing communications materials to one of the MCOs they have contracted with who, in turn, will submit to the State for review. All guidelines established by the State regarding MCOs marketing apply to the providers as well.

PCCMs are exempt from submitting their marketing and outreach materials to the State. However, they must follow the marketing guidelines established for the MCOs operating in the urban areas of the state. The State will ensure that each participating provider is given the marketing guidelines prior to implementation of the PCCM program in their area.

Marketing Guidelines

The following text is a reprint of marketing guidelines distributed by the Authority to MCOs participating in the existing 1915(b) program. The guidelines will remain in force under the 1115(a) program, for both MCOs and PCCM providers.

Overview

The State has developed these marketing guidelines to be used by the MCOs as they develop their communications efforts. Though some of these guidelines are Oklahoma-specific, many are Federal regulations with which each state and their contractors must abide. The State references the more general marketing guidelines in the Request for Proposals that each MCO received. However, these guidelines do not address the specifics of the communications efforts that the MCOs have traditionally employed.

The Authority has closely embraced the concept of mainstreaming the Medicaid population into the commercial health insurance environment. Therefore, careful

attention has been paid to the design and development of these guidelines to assure that this population does not feel estranged from the rest of Oklahoma's insured populations. Through focus groups conducted in Oklahoma City and Tulsa, it was determined that this is of utmost importance to Medicaid recipients. The Medicaid recipients definitely want to have health care like the rest of the commercial populations because it affords them choices that they would otherwise not have under the fee-for-service model of Medicaid.

Oklahoma has designed its Medicaid Managed Care program to incrementally phase in specific populations over time. This presents a certain challenge to the MCOs and the State in that it is not possible to globally address the population as "Medicaid" or "AFDC" due to the confusion it would cause the recipients and county office workers state-wide. Other methods of description are allowable and they are detailed in the following sections.

This document is designed to assist the marketing staffs of the MCOs as well as their contracting providers. It should be referenced in the development of all marketing endeavors. Further, if the MCOs have any suggestions, questions or comments, they are encouraged to communicate them to the State.

***HCFA**'s General Marketing Communications Guidelines*

The most fundamental of the marketing guidelines is that all materials must be submitted to the State for review. These materials consist of, but are not limited to: flyers, ads, letters, brochures, sponsored events, etc. It is imperative that each Health Plan allow for the review process in the development of their communications time line. Further, the Authority assures that the materials will be reviewed in a timely manner. Ten (10) working days would be considered an adequate timeframe for the approval process. However, efforts will be made to complete the review well within this period.

The providers who have contracted with the MCOs are also mandated to submit their marketing communications materials to the Authority for review (See Section XI. Provider/Subcontractor Marketing Guidelines). Should infractions take place on the part of the MCO or providers associated with the MCO, the State will take proper action through the use of sanctions if the infractions are deemed sufficient enough to warrant them.

PCCMs are not mandated to submit their marketing and outreach materials to the State for approval. However, each provider is required to follow the marketing guidelines established for the Health Plans operating in the urban areas of the state.

The following guidelines were provided to the State by HCFA's Office of Managed Care, in conjunction with the Medicaid Managed Care 'Technical Advisory Group. In substance, these guidelines are incorporated in the contracts with the MCOs participating in the ***SooizerCare*** program. The guidelines are designed to be a model in the development of Oklahoma's marketing standards. Further, they provide a general

understanding of what is deemed appropriate and inappropriate for the Medicaid managed care program. This document will help develop consistent interpretations of these guidelines between all the MCOs Plans and the State.

Marketing Materials

1. Contracts should require that all direct marketing materials aimed specifically at the Medicaid population be submitted to the State for review and approval prior to use.

2. Direct marketing materials will be defined as marketing materials in all mediums, including brochures and leaflets, newspaper, magazine, radio, television, billboard and yellow page advertisements, and presentation materials used by marketing representatives. It will include materials mailed to, distributed to, or aimed at Medicaid recipients specifically, and any material that mentions ***Soonercare,*** Medicaid, Medicaid Assistance, or Title XIX.

3. Contracts should state that marketing materials will be disapproved if the State determines that the material is materially inaccurate or misleading or otherwise makes material misrepresentations.

4. Brochures and presentation materials, including handbooks, used by marketing representatives should follow QARI standard X.D. ("Enrollee Rights and Responsibilities, communication of Policies to Enrollees/Members") for minimum level of information to be communicated.

Marketing Communications

5. Contracts must require that MCOs/Outpatient Networks/PCCMs provide those interested in enrolling adequate written description of the organization's rules, procedures, benefits, services, and other information necessary for recipients to make an informed decision about enrollment.

6. Marketing materials should be written in a prose that is readable and easily understood. Material should be available, as needed, in the languages of the major population groups served. A "major" population group is one which represents at least 10% of the Medicaid population in the catchment area served by the HMO.

7. Contracts should prohibit MCOs/Outpatient Networks/PCCMs from engaging in marketing activities that could mislead, confuse or defraud Medicaid recipients, or misrepresent the organization, its marketing representatives, or HCFA. For example, the organization may not assert that a recipient will lose Medicaid benefits if he or she does not enroll in the organization's plan. The organization also may not claim it is recommended or endorsed by HCFA or the Authority.

8. Contracts should prohibit MCOs/Outpatient Networks/PCCMs and their marketing representatives from offering material or financial gain to Medicaid recipients as an inducement to enroll.

   a. MCOs can only use, in marketing materials and activities, any benefit or service that is clearly specified in the contract and available for the full contract period being marketed.

   b. MCOS will be allowed to offer nominal gifts valued at no more than $10 and free health screenings to potential enrollees as long as these gifts and free health screenings are offered whether or not the recipient enrolls in the plan. Free health screenings are not to be used to discourage less healthy potential enrollees from joining the plan.

   c. States may continue to allow MCOs to offer individuals already enrolled in the plan incentives to receive medical care (e.g., to schedule and complete a series of prenatal visits) or to attend educational or preventive health sessions (e.g. nutrition classes, smoking cessation workshops).

Monitoring Enrollment Practices

9. Contracts should require that MCOs will not discriminate, against individuals eligible to be covered under the contract, on the basis of health status or need for future health care services.

10. Contracts should require that no more than 50% of the average marketing representative's total annual compensation, including salary, benefits, bonuses and commissions, comes from commissions.

Monitoring Activities for Plans to Carry Out and States to Oversee

States are required by federal regulation to have procedures to monitor enrollment practices of managed care plans (see **42** C.F.R. **434.63).** One approach is to require in contracts that managed care plans carry out monitoring activities that States will oversee. These can include the following:

   a. MCOs may periodically contact in person a random sample of new enrollees (enrolled within **60** days of the date of contact) to verify their understanding of plan provisions and their decision to enroll.

   b. MCOs should track member satisfaction.

   c. In states where disenrollment is achieved through indirect contact (any method other than face-to-face), plans may periodically survey voluntary disenrollment.

d. Marketer's knowledge and performance may be reviewed periodically.

e. Plans may have individual enrollees, or in the case of minors, their parents or legal guardian, at the time of application for enrollment, sign a statement indicating that they understand key terms and plan provisions. The statement may be part of the enrollment form, but should include a separate signature box from that required for the actual enrollment.

SoonerCare *Marketing Policy and Procedures*

I. Use of ***SoonerCare*** in Marketing Communications

MCOs are prohibited from using the words "Health Plan" subsequent to the ***Soonercare*** registered logo or in body copy so as not to cause confusion with other registered trademarks in the state bearing the name "Sooner".

To keep confusion among Medicaid recipients to a minimum, ***Soonercare*** is considered the sole identifier for the Medicaid managed care program. Therefore, MCOs and their contractors are encouraged to use the ***Soonercare*** logo and/or text in their marketing communications efforts. The usage must comply with all the rules established by the State. This includes all methods of MCO marketing and outreach communications.

The Public Information Office of the Authority can provide the MCOs with the ***SoonerCare*** logo in Tag Image File Format (TIFF) and Encapsulated PostScript (EPS) file formats for desktop publishing purposes. Both Macintosh and IBM formats are supported. Plans may use the images as they are provided by the Public Information Division but may not alter them in any fashion other than size. If MCOs desire a hard copy of the logo, logo slicks are available upon request.

It is not necessary to maintain a standard color for the ***Soonercare*** logo. If MCOs desire to be consistent with the State's enrollment packet, the Pantone matching color is PMS 2945 (Cobalt Blue).

When ***Soonercare*** is used in text, it must always be bolded and italicized.

The ***SoonerCare*** logo and/or text should never be used in the form of an endorsement for an individual Health Plan or provider.

II. Use of Medicaid and AFDC language in Marketing Communications

MCOs are encouraged not to use the words "Medicaid", "AFDC" or "Title XIX" prominently in their marketing materials and advertisements. If "Medicaid", "AFDC" or "Title XIX" are employed in marketing or outreach materials, the State reserves the right to determine if it is contrary to the concept of mainstreaming in the ***Soonercare*** program.

However, Plans can qualify the ***SoonerCare*** program in their body copy or secondary text with a defined use of AFDC as it relates to the populations currently being affected by the transition to managed care. It is recommended that ***SoonerCare*** be used as the major focus.

Medicaid is considered too broad a category to be used in marketing communications at this time because not all Title XIX recipients are currently included in the managed care program. There is only a portion of the Medicaid population affected by the ***SoonerCure*** program. If "AFDC" or "Title XIX" are used in the text of advertisements or radio copy, the catchment area must be clearly defined.

Example of use of AFDC in marketing materials:

"If you live in Comanche County or the Oklahoma City and Tulsa metropolitan areas and are receiving AFDC benefits, you may be affected by the change. Your social worker will tell you if you are eligible for the ***SoonerCare*** program."

111. References to the Oklahoma Health Care Authority

MCOs are authorized to define the Oklahoma Health Care Authority as the State agency responsible for the administration of the Medicaid program in Oklahoma. Further, it is appropriate to refer to the State as the entity where formal grievances are filed. All literature, correspondence or advertisements must be provided to the State to assure accuracy of the definition of the Authority's role in the Medicaid program.

Note: Because of the frequent use of ***SoonerCare*** in the majority of enrollment and educational materials, it would be more appropriate and understandable for the targeted populations to consistently be referred to ***SoonerCure*** with their operational-level questions and comments. Though it is acceptable to refer to the State in MCO literature, correspondence and advertisements, it may cause undue confusion within the eligible populations. References to the State should be reserved for issues such as filing grievances, not to enroll with an MCO.

IV. References to the Department of Human Services (County Offices)

References to the Department of Human Services should be limited to their role in determining eligibility and as the first level of the enrollment process. MCO literature should not direct calls to DHS offices regarding questions about the MCO or benefits. Following the initial managed care offer, DHS offices and social workers are no longer responsible for the operational aspects of the ***SoonerCare*** program.

Note: There will be instances where caseworkers will volunteer to assist the recipients beyond the initial MCO offer. They may allow their clients to contact them if they have any problems or questions. However, this is not considered policy mandated by the State

and the Department of Human Services - it would be determined on an individual-by-individual basis.

V. Two-page MCO inserts in enrollment packet

The Oklahoma Health Care Authority is responsible for the coordination and printing of the ***SooizerCare*** enrollment packets. The MCOs, however, are responsible for providing the State with completed artwork to be included in the MCO comparisons for each region that the plan is participating. The following information outlines the requirements for the artwork:

Size: Two (2) 5 1/2" X **8** 1/2" panels with 3/4" in. margins

Type: 12 pt. Times, double spaced or 24 pt. leading

Format: Macintosh PageMaker 5.0 file with embedded Tag Image File Format (TIFF), Encapsulated PostScript (EPS) and PostScript language PICT files is required for electronic images. All Graphics and fonts (related to logos, logotype or cutlines) should accompany the respective files on 3.5" floppies. If the MCO is unable to provide this format, they will be responsible for producing negatives with the appropriate elements and formatting then providing them to the State in a timely manner.

The State will allow MCOs to change their two-page insert once during the contract year. All MCO changes or an amendments to their two-page insert must be indicated in writing. Further, MCOs must notify the State as soon **as** they determine that changes need to be made so that preparations can be made with the printing contractor. MCOs must provide the State with disks or negatives containing the corrected information before the 10th of the month. If the changes are minimal and the State has resources available, changes can be made by the marketing liaison at the State.

If their is an extreme circumstance that arises where information is found to be incorrect or potentially misleading, the State will allow the MCOs to change their insert more than once. However, the MCOs may be responsible for time and materials resulting from such a change.

Changes can only be included when there is a sufficient need for a reprint of the erirollment materials. Depending on the quantify previously printed, it could be one to three months before changes can be incorporated.

VI, Replicating enrollment materials as marketing tools

MCOs may not use marketing materials that are modeled after the ***Soonercare*** enrollment materials. This can potentially confuse the Medicaid audience and could mislead them in their decision of an MCO.

VII. References to the ***Soonercare*** toll-free number

In the development of the marketing and outreach materials, MCOs are encouraged to only direct those populations currently affected by, or participating in, the ***Soonercare*** program to the ***Soonercare*** toll-free number. Also, materials designed to be delivered to the recipients after they are members of an MCO are appropriate mechanisms for the inclusion of the ***SoonerCare*** toll-free number. General information disseminated to the aggregate at health fairs and county offices is not considered **an** appropriate mechanism for the inclusion of the ***Soonercare*** toll-free number.

If the MCOs desire to give a phone number in their literature related to the ***SoonerCure*** program, they are encouraged to use their individual toll-free member service numbers. If a specific question should arise that the member service operator cannot answer, it should be noted and then reported to the State member enrollment. If necessary, an State representative will contact the individual to answer the question and/or resolve the problem.

VIII. References to the Indian Health Service

Health Plans must clearly indicate that recipients who are IHS beneficiaries must choose **an** MCO and primary care provider or they will be autoassigned but that they have the right to receive services at IHS or tribal facilites or Urban Indian Health Clinics of their choice at any time. It is also necessary to impart the fact that they can change between the Plan's PCPs and a tribal physician at any time, without a referral, and as many times as they desire though they will be required to receive specialty care including, Contract Health Services, through their MCO.

IX. References to Primary Care Providers

MCOs must clearly indicate that the individual PCPs are responsible for MOST of the recipient's medical care. Plans cannot say ALL due to the policies that allow the recipients to self-refer for dental, vision, mental health and family planning services.

X. Description of Health Plan Benefits and Self-Referrals

The description of the recipients' benefits must be in accord with the benefits outlined in the contract. All literature and/or correspondence referencing the "standard" benefits must clearly indicate how the benefits are designed and how they are intended to be delivered. The right to self-refer under areas such as vision, dental, mental health and

substance abuse services as well as family planning must be clearly indicated. Further, beyond being readily apparent, the language used to describe the recipient's benefits and their right to self-refer must be easily understood by the target Medicaid population.

XI. Provider/Subcontractor Marketing Guidelines

1. Providers and subcontractors who are participants in any ***SoonerCare*** MCO networks must abide by the same marketing guidelines as the MCOs themselves.

2. Providers and subcontractors may only contact potential ***SoonerCare*** members with whom they have an established relationship. The Authority defines an established relationship as one where services have been provided within the previous **12** months. Further, careful attention must be paid to delineating the populations that are eligible for the program so as to lessen confusion and unnecessary calls to the county offices. The use of door-to-door solicitation and third party mailing lists are strictly prohibited.

3. Marketing and communication by providers and subcontractors must clearly be based on the continuance of the patient/provider relationship and not be a direct marketing effort for a plan or plans.

4. Providers **and** subcontractors, if contracted with more than one MCO, must list all MCOs they have contracted with in their rnarketing and communication efforts that are designed to inform their patients on who they are affiliated with in the ***SooizerCare*** program. In addition, these materials must be submitted and approved by all the MCOs mentioned.

5. Providers and subcontractors should not contact the State directly with their marketing materials. All questions and marketing materials should first be sent through the marketing departments of the various MCOs with which they have contracted. The MCOs, in turn, will contact the State for final approval. Marketing materials include, but are not limited to: Flyers, Ads, Letters, Brochures, Sponsored Events, etc.

6. The MCOs are responsible for the marketing activities of their providers. Therefore, it is in the best interest of the MCOs to closely monitor their providers so as to assure that infractions do not take place.

XII. Provider Brochure Development

The State will work with providers to produce quality informational materials related to the ***SoonerCare*** program. If there is a specific need to be met, providers and their respective MCOs are encouraged to contact the State to discuss the development of materials that would satisfy the informational demand.

XIII. Television and Radio Communications

MCOs are authorized to use television and radio as marketing and outreach mediums. If television and radio are used, storyboards and scripts must be submitted to the State for approval. Therefore, MCOs are encouraged to develop detailed production timelines that include the State review process.

If television and radio are used as an outreach mechanism, the MCOs must clearly indicate the areas they are participating in if ***SoonerCare*** is used in the copy. For example, if **an** MCOS is only offered in the Oklahoma City metropolitan area, the copy should indicate this. Further, it is not considered appropriate to isolate the targeted population by using "Medicaid" or "AFDC" as a dominant element or theme. ***SoonerCare*** is considered the sole identifier for the Medicaid managed care program.

If the MCO is using television and radio **as** a means of developing name recognition and no reference is made to the ***SoonerCare*** or Medicaid program, it is not necessary to submit storyboards or scripts to the State.

XIV. Billboard Communications

Health Plans are authorized to utilize outdoor communication mechanisms such as billboards and other forms of signage in their marketing efforts. However, it is not appropriate to isolate the targeted population by using "Medicaid" or "AFDC" as a dominant element. Plans are encouraged to use outdoor marketing for individual name recognition or to link themselves with the ***SoonerCare*** program.

XV. Door-to-Door Solicitation

Door-to-Door solicitation is strictly prohibited under the ***SoonerCare*** program. It is considered an infraction of the marketing rules if an activity such as this occurs. Promotional flyers, door-hangers, etc. advertising health fairs and immunization fairs are also affected by this policy unless both health fairs and their advertisements are for the general public.

The Authority cannot enforce this restriction on MCOs who use door-to-door solicitation as a marketing mechanism for commercial populations. However, MCOs who use this marketing mechanism must be certain that none of their materials indicate a relationship with the ***Soonercare*** or Medicaid program. Further, the Authority discourages MCOs from targeting geographic areas that are determined to be lower socioeconomic regions. The Authority will review marketing practices targeted at lower socioeconomic populations very carefully. This restriction also applies to network providers.

XVI. Member Handbooks

Member handbooks should be attractive and easy for the recipient to read and navigate. Further, it should be written between at or below a sixth grade level. The font size should not be below 12 point and significant white space is encouraged.

The following bullets outline the required elements of each MCOs member handbook.

- Services covered by the plan
- Instructions on how to obtain Health Plan-covered services
- Instructions on what to do in an emergency
- Instructions on what to do in an urgent medical situation
- Member options with respect to obtaining family planning services
- Instructions on how to choose a PCP
- Instructions on how to change PCPs
- Toll-free telephone number
- Information to IHS beneficiaries regarding their right to seek out-of-network care at
- Tribal, IHS or Urban Indian Clinics
- Information on the availability and importance of EPSDT services
- Description of the member services function
- Instructions for filing a complaint or grievance
- Instructions on what to do when there is a change in family status
- Description of member rights with respect to confidentiality
- Information on Advanced Directives (Living Wills)

XVII. Member Identification Card

The following bullets outline the required elements of each MCO's identification card.

- Member Name
- OHCA Number (Synonymous with member's Medicaid number)
- Member I.D. number (Assigned by each Health Plan)
- Member's PCP/Clinic-If applicable
- PCP telephone number
- Toll-free Health Plan Member Services telephone number
- 24-hour medical telephone number
- Enrollment effective date

XVIII. Third party mailing lists

At no time shall MCOs purchase or otherwise acquire mailing lists from third-party vendors. Once a recipient has initiated contact with the MCO, they can be added to the MCO's database for future mailings. MCOs should build their mailing databases from those potential recipients who have contacted them.

[See Provider/Subcontractor Marketing Guidelines, Section XI numbers (2) through (4)]

XIX. Newspaper Communications

MCOs can use newspapers as a form of marketing communication. However, it is not considered appropriate to isolate the targeted population by using "Medicaid" or "AFDC" as a dominant element or theme. Plans can qualify the SoonerCare program in their body copy with a defined use of AFDC as it relates to the populations currently being affected by the transition to managed care. Soonercare is considered the sole identifier for the Medicaid managed care program.

If the newspaper medium is used, the MCO must indicate the geographic areas affected by the Medicaid managed care program if Soonercare is used in the copy. For example, if a Plan is only offered in the Oklahoma City metropolitan area, the copy must indicate this.

As with all marketing and outreach materials, at no time should MCOs portray their competitors in a negative light.

XX. DHS County Office Marketing Guidelines

MCOs are provided space in a kiosk to display their printed marketing materials. Plan representatives must keep their allotted space organized and maintained. It is not acceptable to leave marketing materials on tables, chairs, or the floor. Mass produced flyers designed to be taken home by the targeted population must be placed in the kiosk. Materials that are not kept in the kiosk will be discarded on a regular basis.

Representat' es from the various MCOs must limit their visits to county offices to deliver provider directories and marketing materials only.

Each DHS county office will determine if they will allow marketing materials to be displayed on walls and bulletin boards. If approved by the county office, MCOs may utilize no more than two flyers or posters per site. The size of each piece should not exceed 11"X17". Items placed on the walls of the county offices become the property of DHS and are subject to removal if they become outdated or are determined to be misrepresentative of the Soonercare program.

XXI. Health Fairs

MCOs are encouraged to participate in health fairs which are not Soonercare-specific. However, if information is to be disseminated concerning the SoonerCare program, it must be approved by the Authority before the event. This is applicable to both general health fairs and those designed around the targeted SoonerCare populations, if marketing or educational materials concerning SoonerCare are being distributed.

MCOs are prohibited from isolating the Medicaid population in separate areas or rooms at health fair events. At no time should potential ***SoonerCare*** members be isolated from the rest of the health fair population. In addition, MCO representatives should be careful not to presuppose individuals are on Medicaid by their dress or physical appearance and engage in dialogue related to the ***SoonerCare*** program.

MCOs are discouraged from planning health fairs only in traditionally low-income areas in order to assure that the information needs of the entire Medicaid population are met. In addition, the Authority recommends that health fairs be held at facilities that are void of any overt socioeconomic attributes. Churches, public facilities, health care providers' facilities, etc. are considered appropriate sites to conduct health fairs.

It is the responsibility of each MCO to thoroughly educate their marketing and outreach representatives on both the ***SoonerCare*** program as well as their internal policies. The Authority will monitor MCO representatives by occasionally attending health fairs and examining the information provided to the attendees.

The activities, marketing materials and gifts must be tailored and available to both the Medicaid and non-Medicaid populations. In addition, MCOs must distribute their marketing materials and nominal gifts to anyone who requests them.

XXII. Promotional Events

MCOs are encouraged to sponsor or attend promotional events to increase their name recognition as well as educating the citizenry about ***SoonerCare.*** It is imperative that MCO staff members are adequately trained and educated in the ***SoonerCare*** program before they present information to the public. The Authority must approve all marketing materials to be distributed at such events.

XXIII. Gifts

MCOs may distribute nominal gifts at health fairs and promotional events as long as the per unit cost does not exceed $10. The $10 valuation is based on the Manufacturers Suggested Retail Price (MSRP). Further, these gifts should have some health care relevance or reasonable utility for the individuals. Pencils, pens, buttons, balloons, etc., are considered to be nominally priced. Therefore, they are not included in the $10 limit.

Once the recipient becomes a member of an MCO, the Plan can offer gifts in excess of $10 to encourage attendance at new member meetings or orientations. On the other hand, it is imperative that the MCOs not mention these gifts or items in their pre-enrollment marketing materials as an inducement to enroll.

XXIV. Telephone Solicitation

Telephone solicitation of recipients who are not members of an MCO is strictly prohibited. Once a recipient initiates contact with, enrolls in, or is auto-assigned to a Plan, that Plan may contact the individual via telephone on a reasonable basis to inform the member of appointments, upcoming meetings or special events.

XXV. Flyers and Posters

Flyers and posters may be distributed by MCOs at health fairs and promotional events. Mass-produced flyers designed to be taken by Medicaid recipients must be kept in the kiosks at the county offices. Pending approval of individual DHS county offices, Health Plans may post no more than two (2) flyers or posters on the walls or bulletin boards of the facilities. Flyers and posters may not exceed 11"X17" in size. All information contained in the flyers and/or posters must be approved by the Authority before they are distributed.

XXVI. Provider Directories

The production and distribution of provider directories is the responsibility of each MCO participating in the ***SoonerCare*** program. Provider directories are considered not only part of the enrollment process but marketing tools for the MCOs. The Authority requires that each directory contain:

- Name of Physician
- Office Hours
- Physician's Phone Number
- Physician's Address
- Physician's Specialty
- Medicaid Provider Number
- Clinic Affiliation (If Applicable)
- Languages Spoken
- Indicator if taking new patients

A list of all the DHS county offices affected by the Medicaid managed care program has been provided to each plan. The list contains the address, phone number and a contact person for each office. Plans are encouraged to ship the directories before the end of the month to assure that **an** adequate supply is available for social workers.

MCOs must also ship a quantity of the provider lists to the Authority **as** designated by Authority's Member Enrollment Unit. This shipment must be received by the 25th of each month.